**REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY**

**DETAILS OF THE THIRD PARTY ADMINISTRATOR** **(To be filled in block letters)**

a) Name of TPA / Insurance Company : Raksha TPA Pvt. Ltd./
b) Toll free phone number : 1800 180 1444 , 0129 - 4289999
c) Toll free FAX: 0129 - 4289988

**TO BE FILLED BY THE INSURED / PATIENT**

a) Name of the Patient:

b) Gender: ☐ Male ☐ Female c) Age: Years ☐☐ Months ☐☐ d) Contact number:

e) Insured Card ID number: f) Policy Number / Corporate:

g) Employee ID: h) currently do you have any other Mediclaim / Health insurance: ☐ Yes ☐ No

i. Company Name: ii. Give Details :

ii. Policy No. : iv. Sum Insured : ☐☐☐☐☐☐☐

i) Name of the Family physician: j) Contact number:

**TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL**

a) Name of the Treating Doctor: b) Contact number:

c) Nature of ILLNESS / Disease with presenting complaints: _____

d) Relevant Clinical Findings :_____

e) Duration of the Present ailment: ☐☐☐ Days I) Date of First Consultation: ☐☐ ☐☐ ☐☐
II)Past History of Present ailment if any: _____

f) Provisional diagnosis: _____ I) ICD 10 Code

g) Proposed line of Treatment: ☐ Medical Management ☐ Surgical Management ☐ Intensive care ☐ Investigation ☐ Non Allopathic Treatment

h) If Investigation & / or Medical Management Provide Details:_____
I) Route of drug administration: _____

i) If Surgical, Name of Surgery : _____ I) ICD 10 PCS Code:

j) If Other Treatments provide details:_____ k) How did injury occur:_____

**In case of accident**: I) Is it RTA: ☐ Yes ☐ No II) Date of Injury: ☐☐ ☐☐ ☐☐ III) Reported to Police : ☐ Yes ☐ No

IV) Injury / Disease caused due to substance abuse / alcohol consumption: ☐ Yes ☐ No V) Test Conducted to establish this: ☐ Yes ☐ No (If Yes, attach reports)

l) In case of Maternity: ☐ G ☐ P ☐ L ☐ A LMP ☐☐ ☐☐ ☐☐

**Details of patient admitted**

a) Date of admission: ☐☐ ☐☐ ☐☐ b) Time ☐☐ ☐☐

c) Is this an emergency / a planned hospitalization event ?: ☐ Emergency ☐ Planned

d) Expected no. of days stay in hospital : ☐☐☐ Days

e) Room Type :

f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: Rs.

g) Expected cost for Investigation + diagnostics : Rs.

h) ICU Charges : Rs.

i) OT Charges : Rs.

j) Professional fees Surgeon +Anaesthetist fees+consultation Charges: Rs.

k) Medicines + Consumables + Cost of Implants (if Applicable please specify). Other hospital Expenses if any : Rs.

l) All Inclusive package charges if any applicable Rs.

m) **Sum Total expected cost of hospitalization** **Rs.**

**Mandatory: Past History of any chronic illness** **if Yes, since (month/year)**

| | | |
|---|---|---|
| ☐ | Diabetes | ☐☐ ☐☐ |
| ☐ | Heart Disease | ☐☐ ☐☐ |
| ☐ | Hypertension | ☐☐ ☐☐ |
| ☐ | Hyperlididemias | ☐☐ ☐☐ |
| ☐ | Osteoarthritis | ☐☐ ☐☐ |
| ☐ | Asthma / COPD / Bronchitis | ☐☐ ☐☐ |
| ☐ | Cancer, Tumor, Cyst or growth of any kind | ☐☐ ☐☐ |
| ☐ | Alcohol or drug abuse | ☐☐ ☐☐ |
| ☐ | Any HIV or STD / Related ailments | ☐☐ ☐☐ |
| ☐ | Epilepsy or Tuberculosis | ☐☐ ☐☐ |
| ☐ | Any Physical Disablility or Disease of Eye | ☐☐ ☐☐ |
| ☐ | Depression, Mental or psychiatric condition | ☐☐ ☐☐ |
| ☐ | Disorder of bones, joints or muscles | ☐☐ ☐☐ |

☐ Stroke, Anemia ,any Blood Disorder,Chest Pain**,** elevated cholesterol, disorder of kidney or genitor – urinary system, liver disorder, hepatitis (including hepatitis B carrier). ☐☐ ☐☐

☐ Any Disease or Disorder of Brain & Nervous System, Respiratory system, Digestive system or Circulatory system. ☐☐ ☐☐

☐ At any Stage During the past 5 years, have you either been prescribed medication (other than for cold or flu) or received medical treatment/advice on a regular basis. Details _____ ☐☐ ☐☐

Any other Ailment give Details :_____ ☐☐ ☐☐

**DECLARATION** **(PLEASE READ VERY CAREFULLY)**

We confirm having read understood and agreed to the Declarations on the reverse of this form

a) Name of treating doctor:

b) Qualification: c) Registration No. With State Code:

Signature of treating doctor | Hospital Seal (Must include Hospital ID) | Patient / Insured Name & Signature:

## NETWORK HOSPITAL - DECLARATION BY PATIENT/PATIENT'S ATTENDANT

Name of the Hospital :…… Date :……

Address :……

**PATIENT NAME (BLOCK LETTERS) :…… AGE/SEX :……**

**IP No :…… UHID No :…… Mobile No of Patient :……..**

**Date of Admission :…….. Time of Admission :……**

**Date of Discharge :…… Time of Discharge :……..**

**Address of the Patient :……**

**NAME OF THE ATTENDANT :…… Relationship with the Patient :……**

**Mobile No. of Attendant :…….. Address :……**

**Declaration regarding Insurance Policy (Strike off the option which is not applicable)**

**(i)** ***Declaration when patient has no insurance policy:***

- I declare that I do not have any insurance policy.

**(ii)** ***Declaration when patient has insurance policy:***

- I declare that I have following Insurance Policies

***Policy No/TPA card No:_____***

***Insurance Company:_____***

2) Whether patient opted for Eligible Room Category under Policy:
**Yes / No**

3) In case, policyholder wishes to avail better facility:

Name of the Additional Facility/ Provision/ Procedure/ Treatment ……
…….. which costs Rs :……..
(In words: ……
……
……) only.

On my own option, I wish to avail above better facility and I hereby agree to pay on my free will, after being explained in detail by the Hospital authority in my own and understandable language about the above mentioned Additional Facility/Procedure/Treatment and associated cost of it, which is over and above the agreed tariff. Further, if I opt to go for final bill reimbursement with insurance company, respective insurance company will reimburse only as per agreed tariff rates and balance amount will be borne by myself or patient only.

I have also been explained that when room service of a category better than eligible room rent is availed by the patient, not only the difference in room rent but also an equal proportion of all other charges associated with the treatment shall be borne by me.

Signature :……
Name of the Patient/Patient's attendant:

Signature :……
Name of the Hospital Representative & Hospital Seal :

# BREACH CANDY HOSPITAL TRUST

## Cashless Consent Form – Third Party Administrator (TPA)

- I have been explained in details about the cashless facilities at Breach Candy Hospital Trust. I undertake not to hold the hospital responsible for any delay in getting approval or extensions from TPA.

- I have understood that such approvals are my responsibility and the hospital renders this service as a value addition only.

- I will be admitted on the basis of authorization letter received from the insurance Co / TPA which is only a provisional authorization.

- In the absence of an authorization letter, I would be admitted as a "Cash" patient. I would be required to pay the requisite deposit on admission & subsequently clear all hospital bills.

- In case of emergency admission, if the authorization is not received from the insurance Co. / TPA, then I would undertake to clear the bills of the hospital.

- I would have to clear all bills related to exclusions as stated by the Insurance Co. / TPA

- I am aware that subsequent to the pre-authorization and admission a request for confirmation of claim payable is sent to TPA. Only on confirmation from TPA, I will be treated as TPA (Cashless Facility)

- In case I undergo treatment for which the Insurance Co / TPA withdraws authorization or rejects the claim, then I would clear all hospital bills of the hospital.

- I would be required to pay security deposit 48 hrs before the admission. The same will be refunded on settlement from the Insurance Co/ TPA.

- The hospital is not responsible for refusal on part of TPA for reimbursement of my claims.

- I am aware that the original reports and original discharge card are handed over to the Insurance Co/ TPA.

- I am aware that I have to show the copy of the pre-authorization form at the reception on the day of admission to get the cashless benefit.

- I am aware that in planned admission I have to submit the pre-authorization form one week prior to admission and in emergency within 24 hrs. of admission.

- I agree to pay the over and above bill of the approval amount and that I will not seek reimbursement for the same.

Signature of the Patient _____ Signature of the Relative _____

Name of the Patient _____ Name the of Relative _____